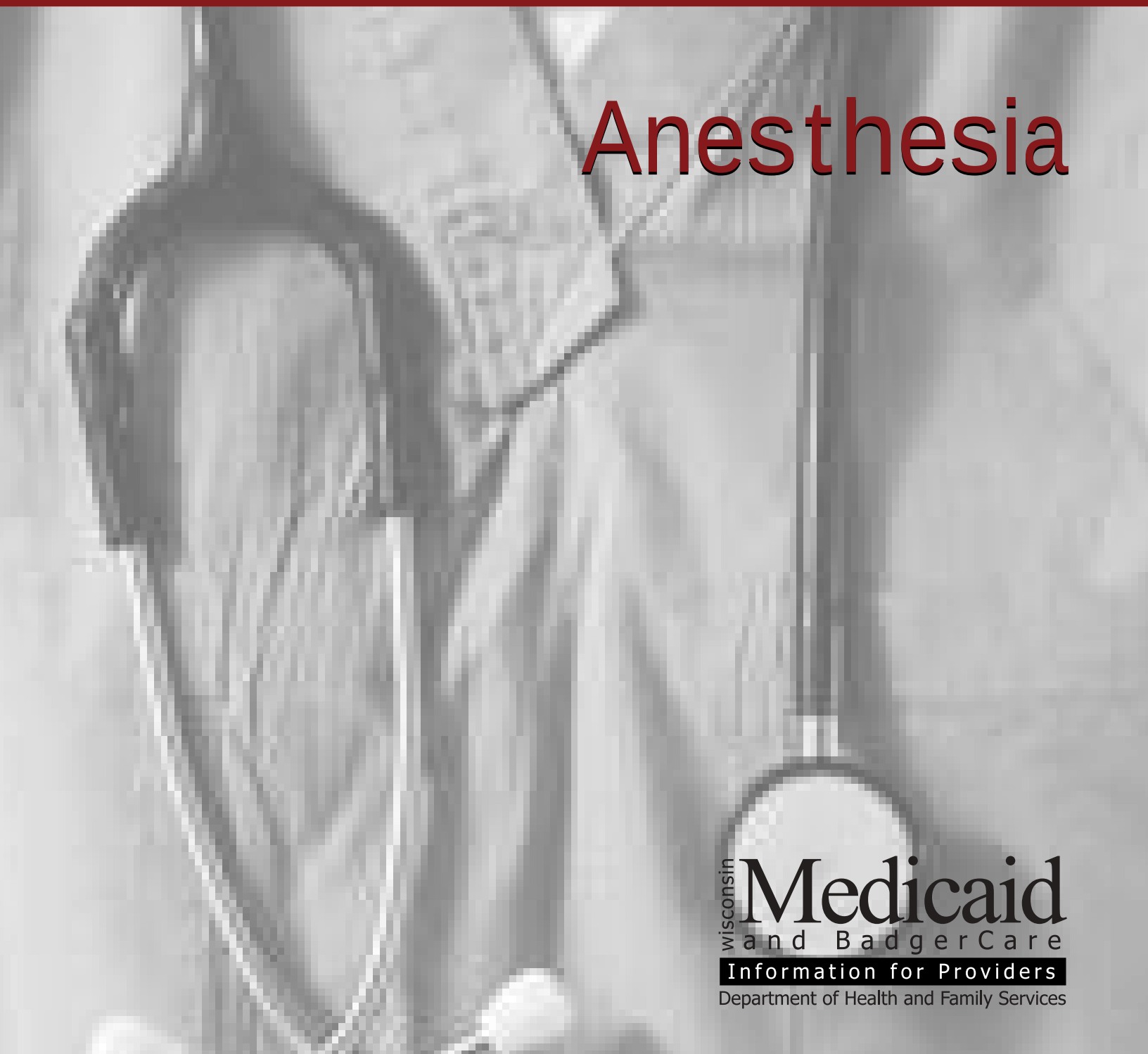
Physician Services

Anesthesia



wisconsin Medicaid and BadgerCare

Information for Providers

Department of Health and Family Services

Important Telephone Numbers

Wisconsin Medicaid's Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information available	Telephone number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Info. Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Info. Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 9:00 p.m. (M, W-F) 9:30 a.m. - 9:00 p.m. (T) 9:00 a.m. - 5:00 p.m. (Sat.)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Info. Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)

*Please use the information exactly as it appears on the recipient's ID card or EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

Table of Contents

Preface 3

General Information 5

- What are Medicaid-Covered Physician Services? 5
- Provider Eligibility and Certification 5
- Types of Provider Numbers 5
  - Billing/Performing Provider Number (Issued to Physicians) 6
  - Group Billing Number (Issued to Clinics) 6
  - Nonbilling/Performing Provider Number (Issued to Physician Assistants) 6
- Recipient Eligibility 6
- Medicaid Managed Care Coverage 7
- Medicaid Abortion Policy 7
  - Coverage Policy 7
  - Noncovered Abortions 7
- Coordination of Benefits 7
  - Health Insurance Coverage 7
  - Medicare Coverage 8
  - Qualified Medicare Beneficiary Only 8
- Electronic Billing 8
- HCFA 1500 Claim Form 9
- Where to Send Your Claims 9
- Claim Submission Deadline 9
- Billed Amounts 9
  - Terms of Reimbursement Agreement 9
  - Medicaid Payment 10
- Reimbursement 10
  - Maximum Allowable Fee Schedule 10
  - Maximum Daily Reimbursement 10
- Follow-Up to Claim Submission 11

Anesthesia Services 13

- Anesthesia 13
  - Procedure Codes 13
  - Time Units 13
  - Multiple Procedures 13
- Qualifying Circumstances 13
  - Procedure Codes 13
  - Quantity 14
- Invasive Monitoring 14
  - Procedure Codes 14
  - Quantity 14

Vascular Procedures 14
Procedure Codes 14
Quantity 14
Epidural Anesthesia 14
Obstetrical 15
Postoperative and Intractable Pain Management 15
Standby Anesthesiologist 15
Additional Anesthesiologist, Nurse Anesthetist, or Anesthesiologist Assistant 16
Anesthesia by Surgeon 16
Abortions, Hysterectomies, and Sterilizations 16

Medical Direction 17

Medical Direction Defined 17
Medical Supervision (Non-Reimbursable) 17
Procedure Code/Modifier 17
Time Units 17
Billing Example for Special Situation 18
More Information 18

Appendix 19

1. Medicaid-Allowable Procedure Codes, Modifiers, Type of Service Codes, and Place of Service Codes for Physician Anesthesia Services 21
2. HCFA 1500 Claim Form Completion Instructions 23
3. Sample HCFA 1500 Claim Form-Physician Anesthesia Services 29
4. Sample HCFA 1500 Claim Form-Physician Anesthesia Services With Qualifying Circumstances 31
5. Sample HCFA 1500 Claim Form-Medical Direction With Qualifying Circumstances 33
6. Sample HCFA 1500 Claim Form-Medical Direction With Third Surgery Begun During Procedure 35

Glossary of Common Terms 37

Index 41

Preface

The Wisconsin Medicaid and BadgerCare Physician Services Handbook is issued to physicians, physician assistants, physician clinics, rural health clinics, blood banks, and federally qualified health centers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% (as of January 2001) of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid and BadgerCare publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility.

Handbook Organization

The Physician Services Handbook consists of the following sections:

- Medicine and Surgery Section.
- Laboratory and Radiology Section.
- Anesthesia Section.

In addition to the Physician Services Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-456 – Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43 - 49.497 and 49.665.

- Regulation: Wisconsin Administrative Code, Rules of Health and Family Services, Chapters HFS 101 - 108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid
www.dhfs.state.wi.us/badgercare

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS, to provide health claims processing, communications, and other related services.

General Information

Wisconsin Medicaid pays only for those services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost-effective.

The Anesthesia section of the Physician Services Handbook includes information for ***anesthesiologists and physician clinics*** regarding covered services, reimbursement methodology, and billing information that applies to fee-for-service Medicaid providers. Wisconsin Medicaid HMOs are required to provide at least the same benefits provided under fee-for-service arrangements. (If you are a Medicaid HMO network provider, contact your managed care organization for information about its requirements.)

What are Medicaid-Covered Physician Services?

Physician services covered by Wisconsin Medicaid are:

- Diagnostic services.
- Preventive services.
- Therapeutic services.
- Rehabilitative services.
- Palliative services.

Wisconsin Medicaid covers only those services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost effective.

Refer to HFS 107.03, Wis. Admin. Code, and to HFS 107.06(5), Wis. Admin. Code, for services ***not covered*** by Wisconsin Medicaid.

Provider Eligibility and Certification

To be certified by Wisconsin Medicaid, physicians must be licensed to practice medicine and surgery pursuant to ss. 448.05 and 448.07, Wis. Stats., and chapters Med 1, 2, 3, 4, 5, and 14, Wis. Admin. Code.

Physicians are asked to identify their practice specialty at the time of certification. Reimbursement for certain services is limited to providers with specific specialties.

Types of Provider Numbers

Wisconsin Medicaid issues all providers, whether individuals, agencies, or institutions, an eight-digit provider number to bill Wisconsin Medicaid for services rendered to eligible Medicaid recipients. A provider number belongs solely to the person, agency, or institution to whom it is issued. It is illegal for providers to bill using a provider number belonging to another provider.

A provider keeps the same provider number in the event that he or she relocates, changes specialties, or voluntarily withdraws from Medicaid and later chooses to be reinstated. (Notify Provider Maintenance of changes in location or of specialty by using the Wisconsin Medicaid Provider Change of Address or Status Form in the Provider Certification section of the All-Provider Handbook. The form is also available on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid.*) A provider's number is not reissued to another provider in the event of termination from Wisconsin Medicaid.

Wisconsin Medicaid issues three types of provider numbers to physicians, physician assistants, and physician clinics. Each type of provider number has its designated uses and restrictions. The three types are:

- Billing/performing provider number.
- Group billing number.
- Nonbilling/performing provider number.

Billing/Performing Provider Number (Issued to Physicians)

Wisconsin Medicaid issues a billing/performing provider number to physicians that allows them to identify themselves on the HCFA 1500 claim form as either the biller of services or the performer of services when a clinic or group is billing for the services.

Group Billing Number (Issued to Clinics)

A group billing number is primarily an accounting convenience. A physician clinic or group using a group billing number receives one reimbursement and one Remittance and Status (R/S) Report for covered services performed by individual providers within the clinic or group.

Individual providers within a physician clinic or physician group must also be Medicaid certified because physician clinics and groups are required to identify the performer of the service on the claim form. (The performing provider's Medicaid provider number must be indicated in element 24K of the HCFA 1500 claim form when a group billing number is indicated in element 33.) Ordinarily, a claim billed with only a group billing number is denied reimbursement. Refer to the HCFA 1500 claim form completion instructions in Appendix 2 of this section for more information.

Nonbilling/Performing Provider Number (Issued to Physician Assistants)

Wisconsin Medicaid issues a nonbilling/performing provider number to physician assistants because they must practice under the professional supervision of a physician to be eligible providers. Physician assistants must be supervised by a physician to the extent required under state regulation and licensing statutes, medical practices statutes, and Med 8, Wis. Admin. Code. A nonbilling/performing provider number may not be used to independently bill Wisconsin Medicaid and is used in one of two ways:

1. To indicate the physician assistant's nonbilling/performing provider number in element 24K of the HCFA 1500 claim form and the supervising physician's name and provider number in element 33 of the claim form. All reimbursement for this claim is made directly to the supervising physician.
2. To indicate the physician assistant's nonbilling/performing provider number in element 24K of the claim form and the clinic's provider number in element 33. All reimbursement for this claim is made directly to the clinic.

Recipient Eligibility

Wisconsin Medicaid providers should ***always*** verify a recipient's eligibility before delivering services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage.

Recipients in the following benefit categories have limitations in their Medicaid coverage:

- Qualified Medicare Beneficiary only (QMB-only).
- Specified Low Income Medicare Beneficiary (SLMB).
- Qualified Disabled Working Individual (QDWI).
- Presumptive Eligibility.
- Illegal (undocumented) aliens.
- Tuberculosis-related.

Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information about these restricted benefit categories and other eligibility issues, such as Lock-In status.

Eligibility information is available from Wisconsin Medicaid's Eligibility Verification System (EVS). The EVS is used by providers to verify recipient eligibility, including whether the recipient is enrolled in a Medicaid HMO, has private health insurance coverage, or is in a restricted benefit category. Providers can

Wisconsin Medicaid providers should ***always*** verify a recipient's eligibility before delivering services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage.

access Medicaid's EVS a number of ways, including:

- Automated Voice Response (AVR) system.
- Magnetic stripe card readers.
- Personal computer software.
- Provider Services.
- Direct Information Access Line with Updates for Providers (Dial-Up).

In most cases, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service.

Refer to the Provider Resources section of the All-Provider Handbook for more information about these methods of verifying recipient eligibility. For more information about recipient eligibility itself, refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook.

Medicaid Managed Care Coverage

Wisconsin Medicaid HMOs are required to provide at least the same benefits provided under fee-for-service arrangements. For recipients enrolled in a Medicaid managed care program, all conditions of reimbursement and prior authorization (PA) for physician services are established by the contract between the managed care program and the provider. Claims submitted to Wisconsin Medicaid for services covered by the recipient's Medicaid managed care program are denied.

Additional information regarding Medicaid managed care program noncovered services, emergency services, and hospitalizations is located in the *Wisconsin Medicaid Managed Care Guide*.

Medicaid Abortion Policy

Coverage Policy

In accordance with Section 20.927, Wis. Stats., Wisconsin Medicaid covers abortions when one of the following situations exists:

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests in a signed, written statement, based on his or her best clinical judgement, that the abortion meets this condition.
- In a case of sexual assault or incest, provided that prior to the abortion the physician attests in a signed, written statement, to his or her belief that sexual assault or incest has occurred, ***and*** provided that the crime has been reported to the law enforcement authorities.
- Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests in a signed, written statement, based on his or her best clinical judgement, that the abortion meets this condition.

Noncovered Abortions

Services incidental to a noncovered abortion are not covered by Wisconsin Medicaid. Such services include, but are not limited to, any of the following services when directly related to the performance of a noncovered abortion: laboratory testing and interpretation, anesthesia, recovery room services, transportation, and follow-up visits.

Refer to the Surgery Services chapter of the Medicine and Surgery section of the Physician Services Handbook for more information about Medicaid policy on noncovered abortions.

Coordination of Benefits

Health Insurance Coverage

In most cases, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. If the recipient is covered under private health insurance, Wisconsin Medicaid reimburses that portion of the allowable cost remaining after private health insurance sources have been exhausted.

In some cases, Wisconsin Medicaid is the primary payer and must be billed *first*. Payers secondary to Medicaid include governmental programs such as:

- Birth to 3.
- The Crime Victim Compensation Fund.
- General Assistance (GA).
- Title V of the Social Security Act, Maternal and Child Health Services, relating to the Program for Children with Special Health Care Needs.
- The Wisconsin Adult Cystic Fibrosis Program.
- The Wisconsin Chronic Renal Disease Program.
- The Wisconsin Hemophilia Home Care Program.

Refer to the Coordination of Benefits section of the All-Provider Handbook for more information on services requiring health insurance billing, exceptions, the Other Coverage Discrepancy Report, and payers secondary to Medicaid.

Medicare Coverage

Recipients covered under both Medicare and Wisconsin Medicaid are referred to as dual entitlees. Claims for Medicare-covered services provided to dual entitlees must be billed to Medicare prior to Wisconsin Medicaid.

If a physician is not Medicare certified, Wisconsin Medicaid requires physicians to be retroactively certified by Medicare for the date the service was provided.

Providers must accept assignment from Medicare for claims for dual entitlees. The dual entitlee is not liable for Medicare's coinsurance or deductible.

Usually, ***Medicare-allowed*** claims (called crossover claims) are automatically forwarded by Medicare to Wisconsin Medicaid for processing. Wisconsin Medicaid reimburses for coinsurance and deductible within certain limits described in the Coordination of Benefits section of the All-Provider Handbook.

Medicaid reimburses for coinsurance and deductible on crossover claims even if the service provided was not a Medicaid-covered service.

If the service rendered to a dual entitlee is covered by Medicare (in at least some situations), but ***Medicare denied*** the claim, submit a new claim to Medicaid and indicate the appropriate Medicare disclaimer code in Element 11 of the HCFA 1500 claim form. Refer to Appendix 2 (element 11) of this section for a list of the Medicare disclaimer codes.

Qualified Medicare Beneficiary Only

Qualified Medicare Beneficiary only (QMB-only) recipients are eligible ***only*** for Wisconsin Medicaid payment of the coinsurance and the deductibles for Medicare-allowed services. Wisconsin Medicaid does not reimburse claims for QMB-only recipients that Medicare does not allow. Physicians must accept assignment from Medicare for claims for QMB-only recipients.

Electronic Billing

Wisconsin Medicaid processes claims that providers submit on magnetic tape (tape-to-tape) or via modem. All claims that providers submit, whether electronic or paper, are subject to the same Medicaid processing and legal requirements. Providers usually reduce their claim errors when they submit claims electronically.

All claims that providers submit, whether electronic or paper, are subject to the same Medicaid processing and legal requirements.

Wisconsin Medicaid provides free software for billing electronically. If you are interested in billing electronically, please call the Electronic Media Claims (EMC) Department at (608) 221-4746 to request the appropriate information. If you are currently using the free software and have technical questions, please contact Proservices' customer service at (800) 822-8050.

All physician anesthesia services may be billed electronically except when billing for an

The fiscal agent must receive properly completed claims for services rendered to eligible Medicaid recipients within 365 days from the date the service was rendered.

additional anesthesiologist or when billing an "unlisted" (nonspecific) procedure code. A claim for an additional anesthesiologist must be submitted on a HCFA 1500 claim form with documentation of medical necessity attached. A claim for an unlisted procedure code must be submitted on the HCFA 1500 claim form with a description of the procedure written in Element 19 of the claim or written on a separate document attached to the claim.

HCFA 1500 Claim Form

Physicians submitting paper claims must use the HCFA 1500 claim form dated 12/90. Wisconsin Medicaid denies claims for physician services submitted on any paper claim form other than the HCFA 1500 claim form. Refer to Appendix 2 of this section for HCFA 1500 claim form completion instructions.

Wisconsin Medicaid does not provide the HCFA 1500 claim form. You may obtain the form from a number of forms suppliers including:

Lakeside Association Services
State Medical Society Services
PO Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
(800) 362-9080 (toll-free)

Where to Send Your Claims

Mail completed HCFA 1500 claim forms for reimbursement to the following address:

Wisconsin Medicaid
Claims and Adjustments
6406 Bridge Road
Madison, WI 53784-0002

Claim Submission Deadline

Wisconsin Medicaid must receive properly completed claims for services delivered to eligible Medicaid recipients within 365 days from the date the service was rendered. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the 365-day claim submission deadline and requirements for submission to Late Billing Appeals can be found in the Claims Submission section of the All-Provider Handbook.

Billed Amounts

Providers are to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits. For providers using a sliding fee scale for specific services, the usual and customary charge is the median (i.e., 50% of charges are above and 50% are below) of the individual providers' charge for the service when provided to non-Medicaid patients.

Under section 49.43(1m), Wis. Stats., "charge" means "the customary, usual and reasonable demand for payment as established prospectively, concurrently or retrospectively," which may not "exceed the general level of charges by others who render such services or care, or provide such commodities, under similar or comparable circumstances within the community in which the charge is incurred."

For providers who have not established usual and customary charges, Medicaid charges should be reasonably related to the provider's cost to provide the services.

Terms of Reimbursement Agreement

As part of Wisconsin Medicaid certification, providers sign an agreement to:

- Bill Wisconsin Medicaid in accordance with Wisconsin Medicaid requirements, including billing usual and customary charges by most providers.

- Accept Wisconsin Medicaid's Terms of Reimbursement, as defined in their Wisconsin Medicaid certification packet.

Medicaid Payment

Wisconsin Medicaid reimburses fee-for-service providers the lesser of the following:

1. Medicaid's maximum allowable fee for the service.
2. The provider's usual and customary charge.

Reimbursement

Wisconsin Medicaid's usual reimbursement for ***general anesthesia*** and ***medical direction*** is equal to the lesser of the billed amount and the relative value units (RVUs) for the major procedure plus the number of 15-minute time units, multiplied by the maximum allowable fee for the procedure.

For example, if the RVU for the surgical procedure provided is 4.00, the maximum allowable fee $17.00, and the surgery lasted an hour and a half (which translates to a billed quantity of 6.0), the Medicaid reimbursement would be calculated as follows:

(4+6) x 17.00 = $170.00

The RVU and the maximum allowable fee assigned to each procedure code is indicated on the maximum allowable fee schedule.

Since the RVU includes usual pre- and postoperative visits, the administration of the anesthetic, and incidental administration of fluids and/or blood, Wisconsin Medicaid will not reimburse these services in addition to the reimbursement for anesthesia.

The reimbursement formula for ***qualifying circumstance*** procedure codes 99100, 99116, 99135, and 99140 is the same as the formula for general anesthesia, except that the quantity for qualifying circumstances is always one. Reimbursement for qualifying circumstance procedure codes 36488, 36489, 36620, and 93503 is equal to the lesser of the billed amount and the maximum allowable fee for the procedure.

Vascular procedures are separately reimbursed only when performed outside the surgical suite and are reimbursed the lesser of the billed amount and the quantity multiplied by the maximum allowable fee for the procedure.

Maximum Allowable Fee Schedule

You are encouraged to obtain a schedule of Wisconsin Medicaid maximum allowable fees for anesthesia services from one of the following sources:

- Paper, microfiche, and 3480 tape cartridge versions are available for purchase using the order form located in the Claims Submission section of the All-Provider Handbook.
- An electronic version that can be downloaded from the *EDS-EPIX* bulletin board, using directions located in the Claims Submission section of the All-Provider Handbook.
- An electronic version on Wisconsin Medicaid's web site at *www.dhfs.state.wi.us/medicaid/*.

Maximum Daily Reimbursement

A provider's reimbursement for all services performed on the same date of service for the same recipient may not exceed the amount established by Wisconsin Medicaid, except for services lasting over six hours. As of July 1, 2000, the maximum amount is $2,259.37. Provider reimbursement potentially exceeding this amount is limited to the maximum amount and a message appears on the Remittance and Status (R/S) Report informing the provider of the limit.

A service exceeding six hours must first be billed to Medicaid in the usual manner. After the reimbursement is received, additional reimbursement may be requested by submitting an Adjustment Request Form ***with the anesthesia record*** to the fiscal agent. Refer to

Wisconsin Medicaid takes no further action on a denied claim unless the information is corrected and the provider resubmits the claim for processing.

the Claims Submission section of the All-Provider Handbook for a sample Adjustment Request Form and instructions.

Follow-Up to Claim Submission

Providers, not Wisconsin Medicaid, initiate follow-up procedures on Medicaid claims. Processed claims appear on the R/S Report either as paid, pending, or denied.

Wisconsin Medicaid takes no further action on a denied claim unless the provider corrects the information and resubmits the claim for processing.

If a claim is paid incorrectly, the provider must submit an Adjustment Request Form to Wisconsin Medicaid. The Claims Submission section of the All-Provider Handbook includes detailed information regarding:

- The R/S Report.
- Adjustments to paid claims.
- Return of overpayments.
- Duplicate payments.

Anesthesia Services

Anesthesia

Procedure Codes

Wisconsin Medicaid coverage of anesthesia services is based on the surgical, therapeutic, or diagnostic procedure performed by the surgeon and is identified by the *Current Procedural Terminology* (CPT) procedure code which best describes the procedure performed. ***Wisconsin Medicaid does not reimburse the CPT anesthesia codes*** (00100-01999) except on Medicare crossover claims. ***Neither does Wisconsin Medicaid recognize patient status modifiers P1-P6***, as described in the anesthesia section of CPT.

Refer to Appendix 1 of this section for Wisconsin Medicaid-allowable procedure codes, modifiers, type of service (TOS) codes, and place of service (POS) codes for physician anesthesia services.

Do not bill relative value units (RVUs) for the procedure performed.

Refer to Appendix 1 of this section for Wisconsin Medicaid-allowable procedure codes, modifiers, type of service (TOS) codes, and place of service (POS) codes for physician anesthesia services.

Time Units

Anesthesia time is billed to Wisconsin Medicaid by indicating the number of ***15-minute time units*** required for the major procedure performed in element 24G (Days or Units) of the HCFA 1500 claim form.

Do ***not*** bill RVUs for the procedure performed. Wisconsin Medicaid automatically includes RVUs when reimbursement is calculated. Do not add RVU and time units. Do not indicate the actual time in minutes or hours.

Anesthesia time begins when the anesthesiologist, certified registered nurse anesthetist (CRNA), or anesthesiologist assistant (AA) physically starts to prepare the recipient for the induction of anesthesia in the operating room and ends when the person performing the anesthesia service is no longer in constant attendance (when the recipient may be safely placed under postoperative supervision).

Rounding Guidelines

Time (in minutes)	Unit(s) Billed
1-15	1.0
16-30	2.0
31-45	3.0
46-60	4.0
61-75	5.0
76-90	6.0
91-105	7.0
106-120	8.0
etc.	

Multiple Procedures

Wisconsin Medicaid reimburses anesthesia only for the CPT procedure code applicable to the ***major*** surgical, therapeutic, or diagnostic procedure performed when multiple procedures are performed in a single surgical session. Assign to that procedure code the number of 15-minute time units involved in the ***total*** surgical session.

Qualifying Circumstances

Procedure Codes

Anesthesia services are sometimes provided under difficult circumstances including:

- Extraordinary condition of the patient.
- Special operative conditions.
- Unusual risk factors.

When these circumstances occur, the ***performing or supervising anesthesiologist*** may bill an appropriate qualifying circumstance procedure code(s) in addition to the CPT code

which best describes the surgical, therapeutic, or diagnostic procedure.

The qualifying circumstance procedure codes listed below are allowed by Wisconsin Medicaid when billed with TOS "7":

Code	Description
99100	Anesthesia for patient of extreme age, under one year and over 70
99116	Anesthesia complicated by utilization of total body hypothermia
99135	Anesthesia complicated by utilization of controlled hypotension
99140	Anesthesia complicated by emergency conditions (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.)

Quantity

More than one qualifying circumstance procedure code may be indicated on the claim, but only a quantity of "1.00" may be billed for each.

Invasive Monitoring

Procedure Codes

Wisconsin Medicaid reimburses the following invasive monitoring procedure codes when performed by an anesthesiologist and billed with TOS "7":

Code	Description
36488	Placement of central venous catheter; percutaneous, age 2 years or under
36489	Placement of central venous catheter; percutaneous, over age 2
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion; percutaneous
93503	Insertion and placement of flow directed catheter for monitoring purposes

Quantity

Indicate a quantity of "1.00" when billing for invasive monitoring.

Vascular Procedures

Procedure Codes

An anesthesiologist may be separately reimbursed for vascular procedures when performed in situations other than in the surgical suite. The following CPT vascular procedures may be reimbursed when billed with TOS "2":

Codes	Description
36000 to 36248	Intravenous and Intra-Arterial/ Intra-Aortic injections
36488 to 36491	Placement of central venous catheter
36600 to 36660	Arterial catheterization

Wisconsin Medicaid does not reimburse anesthesiologists for qualifying circumstance procedure codes when the provider is also billing vascular procedures.

Quantity

Indicate the number of services provided as the quantity billed. Do not report the number of 15-minute time units when billing these codes with TOS "2."

Epidural Anesthesia

Wisconsin Medicaid does ***not*** reimburse separately for anesthesia time when an

An anesthesiologist may be separately reimbursed for vascular procedures when performed in situations other than in the surgical suite.

Wisconsin Medicaid reimburses anesthesiologists for epidural procedures provided for management of postoperative or intractable pain.

epidural anesthesia procedure is performed, except as part of labor and delivery.

Obstetrical

An anesthesiologist's time spent in *constant attendance* with an obstetrical patient receiving epidural anesthesia as part of labor and delivery may be reimbursed. Time spent in constant attendance includes:

- Initiation of the epidural.
- Initial care.
- Intermittent face-to-face monitoring.
- Discontinuation of the epidural.

Providers should bill the appropriate labor and delivery procedure code, TOS "7," and appropriate 15-minute time units. Document in the recipient's medical record or anesthesia report the time actually spent in constant attendance with the recipient.

Wisconsin Medicaid does ***not*** reimburse for standby anesthesia services provided to recipients who have received an epidural during labor or delivery.

Example: Epidural Anesthesia for Labor
CPT Code 62318. Bill for procedure then add time units as follows (15 minutes = 1.0 unit)

Time (24-hour clock)	**Description**	**Time units**
2230 - 2245	Epidural catheter inserted; prepare and drape; check blood pressure and pulse	1.0
0200 - 0215	Check previously inserted epidural catheter, blood pressure, and pulse	1.0
0415 - 0430	Check previously inserted epidural catheter, blood pressure, and pulse	1.0
0510 - 0530	Baby girl delivered at 0530; check blood pressure and pulse	2.0
0540 - 0555	Epidural catheter removed intact; sterile dressing applied to puncture site	1.0
	Billable units	**6.0**

Postoperative and Intractable Pain Management

Wisconsin Medicaid reimburses anesthesiologists for epidural procedures provided for management of postoperative or intractable pain. Indicate the appropriate CPT surgical code related to epidural anesthesia, TOS "2," and a quantity of "1.0." Do ***not*** indicate the number of 15-minute time units as the quantity.

Any subsequent daily visit with the recipient related to the epidural procedure should be billed with the appropriate CPT evaluation and management procedure code and TOS "1." If more than one visit is required, submit an Adjustment Request Form (refer to the Claims Submission section of the All-Provider Handbook) with appropriate documentation and state "Medical Consultant Review Requested."

Standby Anesthesiologist

Wisconsin Medicaid reimburses for a standby anesthesiologist when the attending physician requests an anesthesiologist be immediately available on the premises. The standby anesthesiologist monitors the recipient's vital signs and observes the recipient, even though the surgery is actually being performed under local anesthesia. Wisconsin Medicaid reimburses the standby anesthesiologist as if general anesthesia had been administered. A standby anesthesiologist is covered only when medically necessary and documented in the recipient's medical record.

Standby anesthesia is not covered when anesthesia, including an epidural, has already been administered.

To bill for standby anesthesia, include the following on the HCFA 1500 claim form:

- The procedure code best describing the procedure performed.
- TOS "7."
- The number of 15-minute time units the anesthesiologist was face-to-face with the

recipient or immediately available on the premises during a procedure.

Additional Anesthesiologist, Nurse Anesthetist, or Anesthesiologist Assistant

An additional anesthesiologist, CRNA, or AA may be required in certain surgical situations. Reimbursement for the additional provider is established by the Medicaid medical consultant.

Anesthesia by Surgeon

Reimbursement for anesthesia provided by the surgeon (e.g., local infiltration, digital block, topical anesthesia, regional, and general anesthesia) is included in the Medicaid reimbursement for the surgical or diagnostic procedure(s) performed and is not separately reimbursable.

However, if the anesthesia is the primary procedure performed for diagnosis or treatment, it is separately reimbursable. For example, if an intercostal nerve block is done for diagnosis and treatment of postherapeutic neuralgia, and an epidural steroid injection procedure is also done, the anesthetic procedure is separately reimbursable.

Abortions, Hysterectomies, and Sterilizations

Wisconsin Medicaid requires surgeons to attach specific documentation to their claim when billing for an abortion, a hysterectomy, or a sterilization procedure. If the surgeon does not attach the required documentation, the surgeon's claim and ***all*** other claims related to the surgery are denied reimbursement. This includes the anesthesiologist's claim. Therefore, verify with the surgeon's office that the surgeon has obtained the necessary documentation ***before*** the surgery is performed.

For more information about Wisconsin Medicaid's requirements for reimbursing abortion, hysterectomy, and sterilization claims, refer to the Medicine and Surgery section of the Physician Services Handbook.

Wisconsin Medicaid requires surgeons to attach specific documentation to their claim when billing for an abortion, a hysterectomy, or a sterilization procedure.

Medical Direction

Wisconsin Medicaid reimburses anesthesiologists for *medical direction* of one, two, three, or four certified registered nurse anesthetists (CRNAs) or anesthesiologist assistants (AAs). This is only applicable during concurrent surgeries within a surgical suite. The concurrent surgeries do not have to involve Wisconsin Medicaid recipients.

Medical Direction Defined

Medically directed anesthesia services are those services performed by a CRNA or an AA and directed by an anesthesiologist. When a CRNA or AA is medically directed, the anesthesiologist must do all of the following:

Medically directed anesthesia services are those services performed by a CRNA or an AA and directed by an anesthesiologist.

1. Perform pre-anesthesia examination and evaluation.
2. Prescribe the anesthesia plan.
3. Personally participate in the most demanding procedures of the anesthesia plan, including induction and emergence, if applicable.
4. Monitor at frequent intervals the course of anesthesia administered.
5. Remain physically present on premises and available for immediate diagnosis and treatment of emergencies.
6. Indicate post-anesthesia care.

Wisconsin Medicaid does not reimburse anesthesiologists for general oversight of a surgical suite.

Medical Supervision (Non-Reimbursable)

Medically supervised anesthesia services are those services performed by a CRNA and supervised by the attending physician. Wisconsin Medicaid does not reimburse physicians for medical supervision of CRNAs.

Procedure Code / Modifier

Anesthesiologists bill for medical direction with the appropriate surgical, therapeutic, and diagnostic *Current Procedural Terminology* (CPT) procedure code directly followed by the appropriate supervisory modifier in element 24D of the HCFA 1500 claim form. Refer to Appendix 2 (element 24D) of this section for a list of the modifiers.

When qualifying circumstances for anesthesia exist, the supervising anesthesiologist may receive additional reimbursement by billing a qualifying circumstance procedure code from the list on page 14. (CRNAs and AAs may not receive additional reimbursement for qualifying circumstances.)

Time Units

When billing for medical direction of CRNAs or AAs, indicate the number of ***15-minute time units*** used for the surgical, therapeutic, or diagnostic procedure in element 24G of the HCFA 1500 claim form.

Rounding Guidelines

Time (in minutes)	Unit(s) Billed
1-15	1.0
16-30	2.0
31-45	3.0
46-60	4.0
61-75	5.0
76-90	6.0
91-105	7.0
106-120	8.0
121-135	9.0
etc.	

Billing Example for Special Situation

In this example, the number of CRNAs being medically directed changes during surgery: an anesthesiologist begins a three-hour surgery directing two CRNAs. After one hour, a third surgery begins and the anesthesiologist directs the CRNA for that surgery as well. The anesthesiologist bills for the three-hour surgery on two detail lines of the HCFA 1500 claim form. On the first detail line the doctor indicates the surgical procedure code, the modifier W2 (medical direction of two CRNAs/AAs), and a quantity of 4.0.

The remainder of the time is billed on the second detail line. The procedure code is the same as that on the first line, but the modifier is W3 (medical direction of three CRNAs/AAs) to represent the third CRNA. Because the doctor directed the three CRNAs for two hours, the quantity is 8.0. Refer to Appendix 6 for an example of this claim.

More Information

For more information on billing for the services of CRNAs and AAs, refer to the Nurse Anesthetist and Anesthesiologist Assistant Services Handbook. Providers may obtain a paper copy of the handbook by calling Provider Services at (800) 947-9627 or (608) 221-9883. The handbook is also available on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

Appendix

Appendix 1

Medicaid-Allowable Procedure Codes, Modifiers, Type of Service Codes, and Place of Service Codes for Physician Anesthesia Services

Some procedure codes displayed within ranges below may not be covered by Wisconsin Medicaid. Consult the Physician Services Maximum Allowable Fee Schedule or call Provider Services regarding coverage of specific procedure and type of service (TOS) code combinations. The chart below is periodically revised. Refer to the other sections of the Physician Services Handbook for evaluation and management, laboratory, medicine, radiology, and surgery procedure codes.

Wisconsin Medicaid-Allowable Anesthesia Services

Service	Procedure Codes	TOS
Surgery	10040-69999	7
Vascular procedures	36000-36248, 36488-36491, 36600-36660	2 (when anesthesia is not provided)
Invasive monitoring	36488, 36489, 36620, 93503	7
Radiology	70010-79999 (Anesthesia for radiology procedures is allowed only if the complexity of the procedure and the physical condition of the patient make it medically necessary.)	7
Medicine - psychiatry	90870, 90871	7
Medicine - ophthalmology	92018, 92019	7
Medicine - special otorhinolaryngologic services	92502	7
Medicine - cardiovascular	92950-92998, 93278-93660, 93724, 93731-93738, 93799, 93875-93990	7
Medicine - pulmonary	94799	7
Medicine - qualifying circumstances for anesthesia	99100-99140	7

Modifiers for the Medical Direction of Anesthetists

Service	Procedure Codes	Modifier
Medically directing 1 certified registered nurse anesthetist (CRNA) or anesthesiologist assistant (AA)	10000-79999	W1
Medically directing 2 CRNAs/AAs	10000-79999	W2
Medically directing 3 CRNAs/AAs	10000-79999	W3
Medically directing 4 CRNAs/AAs	10000-79999	W4

POS Codes

POS	Description
0	Other
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
7	Nursing Home
8	Skilled Nursing Facility
B	Ambulatory Surgical Center

TOS Codes

TOS	Description
2	Surgery
7	Anesthesia

Appendix 2

HCFA 1500 Claim Form Completion Instructions

Use the following claim form completion instructions, ***not*** the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. Complete the elements listed below as appropriate. No other elements are required.

Note: Medicaid providers should ***always*** verify recipient eligibility before rendering services.

Element 1 - Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a - Insured's I.D. Number

Enter the recipient's 10-digit Medicaid ID number. Do not enter any other numbers or letters.

Element 2 - Patient's Name

Enter the recipient's last name, first name, and middle initial. Write the name exactly as it appears on the Medicaid ID card.

Element 3 - Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify if male or female with an "X."

Element 5 - Patient's Address

Enter the complete address of the recipient's place of residence.

Mother/Baby Claims

A provider may submit claims for an infant if the infant is 10 days old or less on the date of service and the mother of the infant is a Medicaid recipient. To bill for an infant using the mother's Medicaid identification number, enter the following:

Element 1a: Enter the mother's 10-digit Medicaid ID number.
Element 2: Enter the mother's last name followed by "newborn."
Element 3: Enter the ***infant's*** date of birth.
Element 4: Enter the mother's name followed by "mom" in parentheses.
Element 21: Indicate the secondary or lesser diagnosis code "M11" in fields 2, 3, or 4.

Element 9 - Other Insured's Name

Third-party insurance (private insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require third-party billing as determined by Wisconsin Medicaid.

- When the recipient has dental (DEN) insurance only or has no private insurance, leave element 9 blank.
- When the recipient has Wausau Health Protection Plan (HPP), Blue Cross (BLU), Wisconsin Physicians Service (WPS), CHAMPUS (CHA), or some other (OTH) private insurance, ***and*** the service requires third party billing according to the Coordination of Benefits section of the All-Provider Handbook, one of the following three other insurance (OI) explanation codes ***must*** be indicated in the ***first*** box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by health insurance. In Element 29 of this claim form, indicate the amount paid by health insurance to the provider or to the insured.

OI-D DENIED by health insurance following submission of a correct and complete claim, ***or*** payment was applied towards the coinsurance and deductible. Do ***not*** use this code unless the claim was actually billed to the health insurer.

OI-Y YES. The recipient has health insurance, but it was not billed for reasons including, but not limited to:

- ✓ Recipient denied coverage or will not cooperate.
- ✓ The provider knows the service in question is not covered by the carrier.
- ✓ Health insurance failed to respond to initial and follow-up claims.
- ✓ Benefits not assignable or cannot get assignment.

- When the recipient is a member of a commercial HMO, one of the following must be indicated, ***if applicable***:

Code	Description
OI-P	PAID by HMO. The amount paid is indicated on the claim.
OI-H	HMO does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 11 - Insured's Policy, Group or FECA Number

Use the ***first*** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Bill Medicare before billing Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- The recipient's Wisconsin Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A. Services related to a diagnosis of chronic renal failure are the only exceptions.
- The ***non-physician*** provider's Wisconsin Medicaid file shows he or she is not Medicare certified. (This does not apply to physicians because Medicare will retroactively certify physicians for the date and the service provided if they held a valid license when the service was performed.)
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits (EOMB), but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary.

Appendix 2
(continued)

Use the following applicable Medicare disclaimer codes when appropriate:

Code	Description
M-1	**Medicare benefits exhausted.** This code can be used when Medicare has denied the charges because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use the M-1 disclaimer in these two instances only: *For Medicare Part A* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. • The recipient is eligible for Medicare Part A. • The service provided is covered by Medicare Part A but is not payable due to benefits being exhausted. *For Medicare Part B* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. • The recipient is eligible for Medicare Part B. • The service provided is covered by Medicare Part B but is not payable due to benefits being exhausted.
M-6	**Recipient not Medicare eligible.** This code can be used when Medicare denies payment for services related to ***chronic renal failure*** (diagnosis code "585") because the recipient is not eligible for Medicare. Medicare must be billed first, even when the recipient is identified in Wisconsin Medicaid files as not eligible for Medicare. Use the M-6 disclaimer code in these two instances only: *For Medicare Part A* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. • Medicare denies the recipient eligibility. • The service is related to chronic renal failure. *For Medicare Part B* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. • Medicare denies the recipient eligibility. • The service is related to chronic renal failure.
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only: *For Medicare Part A* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. • The recipient is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, etc. *For Medicare Part B* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. • The recipient is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, etc.

Code	Description
M-8	**Noncovered Medicare service.** This code can be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered. Use M-8 in these two instances only: *For Medicare Part A* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. • The recipient is eligible for Medicare Part A. • The service is usually covered by Medicare Part A but not under certain circumstances related to the recipient's diagnosis. *For Medicare Part B* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. • The recipient is eligible for Medicare Part B. • The service is usually covered by Medicare Part B but not under certain circumstances related to the recipient's diagnosis.

Element 19 - Reserved for Local Use

If you bill an unlisted (or not otherwise specified) procedure code, you must describe the procedure. If element 19 does not provide enough space for the procedure description, or if you are billing multiple unlisted procedure codes, you must attach documentation to the claim describing the procedure(s). In this instance, indicate "See Attachment" in element 19. Do not bill unlisted procedure codes through electronic billing. Unlisted procedure codes are required to be submitted through paper claim submission.

Element 21 -Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Wisconsin Medicaid denies claims without the appropriate ICD-9-CM diagnosis code. One source to order the complete ICD-9-CM code book is:

St. Anthony Publishing, Inc.
P. O. Box 96561
Washington, D.C. 20090
(800) 632-0123

Element 24A - Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four dates of service on the same detail line, enter the first date of service in MM/DD/YY or MM/DD/YYYY format in the "From" field, and subsequent dates of service in the "To" field by listing ***only*** the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service (TOS) code.
- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge ***per detail line*** in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

Element 24B - Place of Service

Enter the appropriate Medicaid single-digit POS code for each service. Refer to Appendix 1 for a list of POS codes.

Element 24C -Type of Service

Enter "2" for vascular procedures and "7" for anesthesia procedures.

Element 24D - Procedures, Services, or Supplies

Enter the single most appropriate five-character *Current Procedural Terminology* (CPT) code, HCFA Common Procedure Coding System (HCPCS) code, or local procedure code. Claims received without the appropriate CPT, HCPCS, or local code are denied by Wisconsin Medicaid.

Each year, Wisconsin Medicaid adopts the most current CPT and HCPCS procedure codes. (The exact date is announced in a Remittance and Status [R/S] Report message.) Therefore, providers must use the Medicaid Physician Services Handbook in conjunction with the most current CPT and HCPCS procedure code book.

Modifiers

Enter the appropriate two-character modifier in the "Modifier" column of element 24D. Wisconsin Medicaid only accepts specific modifiers that are appropriate to the procedure billed. Please note that Wisconsin Medicaid has ***not*** adopted all CPT, HCPCS, or Medicare modifiers. Use the following list of allowable procedure codes and modifiers for the medical direction of Certified Registered Nurse Anesthetists or Anesthesiologist Assistants (CRNAs/AAs):

Service	Procedure Codes	Modifier
Medically Directing 1 CRNA/AA	10000-79999	W1
Medically Directing 2 CRNAs/AAs	10000-79999	W2
Medically Directing 3 CRNAs/AAs	10000-79999	W3
Medically Directing 4 CRNAs/AAs	10000-79999	W4

Element 24E - Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in element 21.

Element 24F - Charges

Enter the total charge for each line item.

Element 24G - Days or Units

Enter the appropriate number of units, time units, qualifying circumstance units, or other services billed for each line item. Always use a decimal (e.g., 2.00 units). Do ***not*** indicate the relative value units (RVUs) of the surgical, therapeutic, or diagnostic procedure performed.

Element 24H - EPSDT/Family Planning

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if ***both*** HealthCheck and family planning services were provided. If HealthCheck or family planning do not apply, leave this element blank.

Element 24I - EMG

Enter an "E" for ***each*** procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this element blank.

Element 24K - Reserved for Local Use

Enter the eight-digit, Medicaid provider number of the performing provider ***for each procedure***, if the billing provider indicated in element 33 belongs to a physician clinic or group.

Any other information entered in this element may cause claim denial.

Element 26 - Patient's Account No.

Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the R/S Report.

Element 28 - Total Charge

Enter the total charges for this claim.

Element 29 - Amount Paid

Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.) Do ***not*** enter Medicare paid amounts in this field.

Element 30 - Balance Due

Enter the balance due as determined by subtracting the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier

The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 33 - Physician's, Supplier's Billing Name, Address, ZIP Code and Phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 3

Sample HCFA 1500 Claim Form-Physician Anesthesia Services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID) — **P**

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **1234567890**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Recipient, Im A.**

3. PATIENT'S BIRTH DATE MM DD YY: **MM DD YY** SEX M ☐ F **X**

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): **609 Willow**

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: **Anytown** STATE: **WI**

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: **55555** TELEPHONE (Include Area Code): **(XXX)XXX-XXXX**

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: **M - 7**

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. **575 1** 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
MMDDYYYY		**1**	**7**	**47600**		**1**	**XXX XX**	**8.0**				**12345678**

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.: **1234JED**

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ **XXX XX**

29. AMOUNT PAID $

30. BALANCE DUE $ **XXX XX**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MM/DD/YY
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 **87654321**
PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix 4

Sample HCFA 1500 Claim Form-Physician Anesthesia Services With Qualifying Circumstances

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — P

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX M ☐ F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY — STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX)XXX-XXXX

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 575.1 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		1	7	47600		1	XXXX	8.0		E		12345678
2 MM DD YY		1	7	99135		1	XXXX	1.0		E		12345678
3 MM DD YY		1	7	99140		1	XXXX	1.0		E		12345678
4 MM DD YY		1	7	99105		1	XXXX	1.0		E		12345678
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. BALANCE DUE $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MM/DD/YY
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321
PIN# GRP#

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix 5

Sample HCFA 1500 Claim Form-Medical Direction With Qualifying Circumstances

PICA — **HEALTH INSURANCE CLAIM FORM** — PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)
P

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY — STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX)XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 575.1
2. 284.8
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MMDDYYYY		1	7	47600	W2	1	XXXX	8.0				12345678
2 MMDDYYYY		1	7	99135		2	XXXX	1.0				12345678
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXX.XX

29. AMOUNT PAID $ XX.XX

30. BALANCE DUE $ XX.XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MM/DD/YY
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix 6

Sample HCFA 1500 Claim Form-Medical Direction With Third Surgery Begun During Procedure

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX: M [X] F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX)XXX-XXXX

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

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17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 575.1
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		1	7	47600	W2	1	XXXX	4.0				12345678
2 MM DD YY		1	7	47600	W3	1	XXXX	8.0				12345678
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ XXX.XX

29. AMOUNT PAID $ XX.XX

30. BALANCE DUE $ XX.XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MM/DD/YY
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32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Glossary of Common Terms

AA

Anesthesiologist assistant.

Adjustment

A modified or changed claim that was originally allowed at least in part by Wisconsin Medicaid.

Allowed status

A Medicaid or Medicare claim that has at least one service that is reimbursable.

BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients' health care is administered through the same delivery system.

CPT

Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by Health Care Financing Administration (HCFA) and Wisconsin Medicaid.

CRNA

Certified registered nurse anesthetist.

Crossover Claim

A Medicare-allowed claim for a dual entitlee sent to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

DHCF

Division of Health Care Financing. The Division of Health Care Financing administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides the Health Care Financing Administration (HCFA) and the U.S. Department of Health and Human Services (DHHS) assurances that the program is administered in conformity with federal law and HCFA policy.

DHHS

Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

DOS

Date of service. The calendar date on which a specific medical service is performed.

Dual entitlee

A recipient who is eligible for both Medicaid and Medicare, either Medicare Part A, Part B, or both.

ECS

Electronic Claims Submission. Claims transmitted via the telephone line and fed directly into Wisconsin Medicaid's claims processing subsystem.

Emergency services

A medical condition manifesting itself by acute symptoms, including severe pain, such that a prudent layperson, who possesses an average knowledge of

health and medicine, could reasonably expect the absence of immediate medical attention to result in placement of the individual's health, or in the case of a pregnant woman, the woman and unborn child's health in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of a bodily organ or part.

EOB

Explanation of Benefits. Appears on the provider's Remittance and Status (R/S) Report and notifies the Medicaid provider of the status or action taken on a claim.

EVS

Eligibility Verification System. Wisconsin Medicaid encourages all providers to verify eligibility before rendering services, both to determine eligibility for the current date and to discover any limitations to a recipient's coverage. Providers may access recipient eligibility information through the following methods:

- Automated Voice Response (AVR) system.
- Magnetic stripe card readers.
- Personal computer software.
- Provider Services (telephone correspondents).
- Direct Information Access Line with Updates for Providers (Dial-Up).

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Medicaid fiscal agent (EDS) is under contract with the Department of Health and Family Services to certify providers, process and pay claims, answer provider and recipient questions, issue identification cards to recipients, publish information for providers and recipients, and maintain the Wisconsin Medicaid Web site.

HCFA

Health Care Financing Administration. An agency housed within the U.S. Department of Health and Human Services (DHHS), HCFA administers Medicare, Medicaid, related quality assurance programs, and other programs.

HCPCS

HCFA Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by Health Care Financing Administration (HCFA) to supplement CPT codes.

HealthCheck

Program which provides Medicaid-eligible children under age 21 with regular health screenings.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for medical diagnoses required for billing. Available through the American Hospital Association.

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

Medically necessary

According to HFS 101.03 (96m), a Medicaid service that is:
(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

On-site supervision of CRNAs and AAs

The supervising anesthesiologist is immediately available for consultation or, in the case of an emergency, for direct intervention.

PA

Prior authorization. The written authorization issued by the Department of Health and Family Services (DHFS) to a provider prior to the provision of a service.

POS

Place of service. A single-digit code which identifies the place where the service was performed.

QMB-only

Qualified Medicare Beneficiary under the Medicare Catastrophic Health Act. QMB-only recipients are only eligible for the payment of the coinsurance and the deductibles for Medicare-allowed claims.

Qualifying circumstances

Conditions that complicate the rendering of anesthesia services, including the extraordinary condition of the patient, special operative conditions, and unusual risk factors.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform the provider regarding the processing of the provider's claims.

RVU

Relative value unit. A number assigned by Wisconsin Medicaid to indicate the relative clinical intensity and difficulty of the surgical, diagnostic, or therapeutic procedure code for which anesthesia services were performed. The RVUs are not necessarily equivalent to either federal or American Society of Anesthesiologists' RVUs. RVUs are indicated on Physician Maximum Allowable Fee Schedule.

TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

Index

Abortion
  Documentation, 16
  Incidental services, 7
  Policy, 7

Adjustment Request Form
  Correcting allowed (or paid) claim, 11

Anesthesiologist
  Additional, 16
  Standby, 15

Certification, 5

Claims
  Correcting allowed (or paid) claim, 11
  Correcting denied claim, 11
  Electronic, 8
  Exceeding maximum daily reimbursement, 10
  HCFA 1500, *see* HCFA 1500
  Mother/baby, 23
  Submission deadline, 9
  Where to send, 9

Epidural anesthesia, 14

HCFA 1500
  How to obtain, 9
  Instructions, 23
  Samples, 29, 31, 33, 35

HMO, private, *see* Insurance, private

Hysterectomy, 16

Insurance, private
  Coordination of benefits, 7
  Explanation codes, 23
  Verifying, 6

Invasive monitoring, 14

Maximum allowable fee, 10

Maximum daily reimbursement, 10

Medicare
  Allowed claim, 8
  Assignment, 8
  Denied claim, 8
  Disclaimer codes, 24
  Retroactive certification, 8

Mother/baby claim, 23

Qualified Medicare Beneficiary only (QMB-only), 8

Qualifying circumstances
  Claim sample, 31, 33
  Policy, 13
  Procedure codes, 14
  Quantity, 14
  Reimbursement, 10

Recipient eligibility, 6

Reimbursement
  General anesthesia, 10
  Maximum allowable fee, 10
  Maximum daily reimbursement, 10
  Medical direction, 10
  Qualifying circumstances, 10

Relative value units (RVUs)
  Not billed on claim, 13
  Reimbursement formula, 10

Rounding guidelines
  Anesthesia services, 13
  Medical direction, 17

Standby anesthesiologist, 15

Sterilization, 16

Unlisted (nonspecific) procedure codes, 9

Vascular procedures
  Policy, 14
  Reimbursement, 10